



## VETERINARIAN EDUCATION LOAN REPAYMENT APPLICATION

ND Department of Health  
Division of Health Facilities  
SFN 18571 (12-2007)

Telephone: 701.328.2353

Dept. Use Only

File Number:

Name of Veterinarian				
Home Address	City	State	Zip Code	Home Phone
Office Address	City	State	Zip Code	Office Phone
Other North Dakota Address and Phone where I can be contacted:	City	State	Zip Code	Cell Phone:  E-mail Address:
I prefer to be contacted at <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> Any of the three				
<b>Practice Type</b>  <input type="checkbox"/> Large Animal / Food Animal <input type="checkbox"/> Small Animal <input type="checkbox"/> Large Animal / Equine <input type="checkbox"/> Mixed (predominantly large) <input type="checkbox"/> Government /Research/Teaching <input type="checkbox"/> Mixed (predominantly small)  Other, please specify:				
<b>TRAINING</b>				
Veterinary School			Year of Graduation	
Internship or Externship or Special Training			Year of Completion	
Residency			Year of Completion	
Certification Status  <input type="checkbox"/> NAVLE <input type="checkbox"/> QE <input type="checkbox"/> VCSA		North Dakota License Number or date Exam will be taken:		
<b>Current Status</b>  <input type="checkbox"/> Practicing <input type="checkbox"/> Government <input type="checkbox"/> Student <input type="checkbox"/> Administration <input type="checkbox"/> Internship <input type="checkbox"/> Teaching / Research <input type="checkbox"/> Externship <input type="checkbox"/> Other <input type="checkbox"/> Residency				

Practice Experience	Location	Type	Years		
<b>OUTSTANDING EDUCATION LOANS</b>					
Name of Loan	Lender/ Address	Loan Number	Amount	Balance	Date Loan Must Be Paid
Are you in default on any loans? No <input type="checkbox"/> Yes <input type="checkbox"/> - identify loan and amount.					
How much money are you requesting? (You may request \$30,000 for two years of service) (You may request \$55,000 for three years of service) (You may request \$80,000 for four years of service)					
Name of North Dakota community where you will practice:			Date you will be able to begin		
Do you have a license to practice veterinary medicine in any state or country other than North Dakota?  <input type="checkbox"/> No <input type="checkbox"/> Yes – specify (Location and License Number)					
Has your license been suspended, revoked or surrendered? No <input type="checkbox"/> Yes <input type="checkbox"/> - explain.					
Are you currently in litigation? No <input type="checkbox"/> Yes <input type="checkbox"/> - explain.					
<b>EMPLOYMENT HISTORY (List most recent employer first)</b>					
Employer	Address			Dates Employed	

Were any state-funded student support fees paid on your behalf?

☐ No   ☐ Yes

If Yes, who paid them?

1. Attach three letters of recommendation regarding your professional training and competence.
2. Attach a copy of your North Dakota Veterinary license or send copy when received.
3. Attach letters of support from the community you would like to serve.
4. Attach a statement of your commitment to service the community.
5. Attach your curriculum vitae.

### SIGNATURES AND AFFIDAVIT

I hereby make application for a veterinary loan repayment award subject to the provisions of North Dakota Century Code 43-29.1 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. I also give the North Dakota Department of Health permission to obtain any information from my lender(s) that may be needed to verify the contents of this application; for the North Dakota Department of Health to make payments to my lending institution(s) and for the North Dakota Department of Health to obtain information from the North Dakota University System to determine if any state support payments have been paid on my behalf.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

State of \_\_\_\_\_ )

County of \_\_\_\_\_ )

On this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_, before me personally appeared \_\_\_\_\_ who having been sworn states that to the best of his/her knowledge and belief the statements in the foregoing application are true.

\_\_\_\_\_  
Notary Public

(Seal)

My commission expires \_\_\_\_\_

Return the completed application to:

North Dakota Department of Health  
Office of Community Health  
600 East Boulevard Ave Dept 301  
Bismarck ND 58505-0200